Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001170	A. BUILDING ______ B. WING ______	07/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMOND COMMUNITY AMBULATORY CARE CENTE	**2143 CALUMET AVENUE HAMMOND, IN 46394**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a standard licensure survey. Facility Number: 012066 Survey Date: 07/25-26/2011 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor Hammond Community Ambulatory Care Center is in compliance with 410 IAC 15.2, Ambulatory Surgery Center Licensure Rules. QA: claughlin 08/04/11	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE